UTERINE FIBROIDS COMPLICATING LABOR.*

By F. R. HOREL, M. D., Arcata.

THIS subject, that of uterine fibroids complicating labor, has not been chosen on account of any special knowledge of my own in the management of these most difficult and dangerous cases, but to call your attention to the fact that we know not the day nor the hour when we may be called upon to face a furious, if not a fatal hemorrhage, or, overcoming this, that we may not loose our patient from sepsis, to the end that we may, should such a complication come to us, be prepared to do the best possible for our patient.

I had been in obstetric practice nearly nineteen years, had treated many fibroids of the uterus, but these two are the only ones complicating pregnancy:

Case No. 1. February 7, 1904, I was called at night to see a lady about 27 years old who had always been strong and healthy, the mother of three children, the youngest three weeks old. Labor said to have been normal in every way. Got up the 10th or 11th day feeling well and had gained in strength up to the 20th day, when, without pain or warning of any kind a hemorrhage started, but grew less when in a recumbent position. She felt well and looked well, except being a little pale. On examining I found what I thought to be a uterine fibroid, presenting at the os, very little hemorrhage, so I gave ergot and advised letting matters rest till morning. In the morning, with the assistance of two nurses and patient under anesthetic I operated. Situated in the posterior wall of the uterus, just above the internal os, I found a fibroid the size of a small orange. The capsule had ruptured so it was easy to grasp the tumor with vulsellum forceps. Then began the process of enucleation, which, after some difficulty, was accomplished and the tumor delivered. There was very little hemorrhage. Patient had an uninterrupted recovery and has remained well ever since.

Case No. 2. A well nourished girl of 19 years, family history good, married ten to twelve months. I saw her for the first time since marriage April 11, 1904. Found her in labor, os dilating, breach presentation, two or three weeks short of term. After a wait of some 10 hours, os well dilated, progress slow, under a partial anesthetic, I introduced the hand and changed to footling. The head not coming through readily I applied short forceps and delivered. Placenta expressed under contraction, examined carefully and found to be perfect. No hemorrhage.

Everything went well until the 10th day, when the temperature began to creep up and pulse to quicken, temperature reaching 100°F. Gave small doses of calomel, followed by sol. of mag. citrate. Still the temperature did not go down. Then to my surprise the flow began to increase, changing from dark to bright red. Patient became restless, complaining of backache and severe headache. The 11th day after labor conditions were not improved, temperature 101°, pulse ranging from 100 to 115 and weak; head still aching. No odor to lochia. Contractions weak. Gave ergot and strychnia. The next day, April 23d, twelve days after labor, conditions unchanged, I used a dull curette and flushed uterus out with sterile water. Hemorrhage checked, temperature dropped to 99°, pulse to 100. But the evening of the 24th, the 13th day, and about 30 hours after curettement, hemorrhage started up with a gush. On examination found a hard mass just above internal os. Hasty preparation was made and I grasped with forceps and enucleated a fibroid about the size of a small hen's egg. Capsule had ruptured and it turned out quite easily from its bed, which was in posterior wall, just above internal os.

I again washed out uterus and applied iodin and carbolic acid to capsule and beyond. Hemorrhage ceased, temperature began to decline, but patient was very anemic from loss of blood. Digestion bad, pulse weak, but responded fairly well to strychnia. Dr. Charles Mills of Arcata was then called in consultation and again on the evening of the 26th, two days after the operation, Drs. H. Gross, Sinclair and Mills kindly saw the patient with me in consultation.

Shortly after this the nurse, in giving the normal salt enemas to stimulate the patient, found evidences of impaction, although the nurse had reported the bowels moving every day, they had not been moving enough. This would account for the temperature not going down to normal or below, after the operation, and would also account for the digestive disturbances which kept up until the bowel trouble had been cleared up. She made a rather slow, but good recovery.

I wish to dwell particularly on case No. 2. I do not believe that we should curette every time we are in doubt, on the other hand, I think sometimes we should study what not to do. Had I known of that fibroid I would not have put a curette into the uterus, although it was dull and manipulated very gently. There had been absolutely no symptoms to cause me to suspect its existence, except hemorrhage, and that we get from other causes.

Being small and situated so close to the posterior, uterus relaxed and os patulous, the curette which was a douche combined, slipped in and out with the cause of the trouble still in doubt.

Most writers tell us we should examine and locate these tumors early, note their exact size and location, then should they occupy a position which will be likely to give rise to trouble during labor, myomectomy or hysterectomy should be performed to avoid such complications.

But in cases where the patient has not been seen before labor begins, or where there have been no symptoms before hand causing us to suspect trouble, what are we going to do?

In a paper presented before the County Society of New York, Dr. Marx says:

With few exceptions fibroid tumor of the uterus should at all times, if possible, be treated, or such treatment instituted before the advent of pregnancy. Their association with pregnancy forms a complication which in many patients must be looked upon, not as a benign, but as a malignant state. With hardly another complication in the entire domain of obstetrics are we surrounded with such a mist of doubt as with this one, nor can we ever certify before with what we may meet, immediate or remote. No matter how small or insignificant the tumor may be in the non-pregnant state, no living being can tell, no matter what the location of the tumor, what we may expect during labor; again, that we may not be confronted with an impossible labor, a fatal hemorrhage; or, overcoming these, that our patient may not die of sepsis due to the sloughing of the tumor; or if, then, it may not end with what the pregnancy should have been anticipated by—a hysterectomy. But nature is kind to the poor women with fibroid uteri, for many of them are incapable of conception. Again, should there be found a "fibroid uterus" in any woman who presents herself for such symptoms as would warrant a pelvic examination I would unhesitatingly advise a hysterectomy, except in those few cases where a simple myomectomy could be done, or where there is a vital indication against such a radical measure.

A diagnosis of pregnancy with a safe fibroid tumor as a complication, i. e., one situated at the fundus, is often exceedingly difficult. * * *

Experience teaches us that trouble is to be expected during the third stage of labor and during puerperium. These dangers can be summed up in two words—hemorrhage and sloughing. Fibroids during and after labor must be handled gently and with care, avoiding as much as possible any traumatic insult. The occurrence of adherent placenta due to the concomitant endometritis that goes so often with fibroids is the first complication that may confront us. Forcibly digging away such an afterbirth invites lesions of the tumor capsule proper, and the danger of cutting off its nourishment becomes evident. Where great difficulty is experienced in the enucleation of an adherent placenta under the conditions I would rather be inclined to tightly pack such an organ with gauze, with the placenta in situ, and thus await its natural exit (in perhaps 24 hours) than invite sepsis and sloughing by the extra hazardous and the forcible means of digging out this placenta. Yet, in one case, a total hysterectomy was forced upon me in order to deliver an adherent placenta in a badly diseased fibroid uterus, the attempt to deliver by the vaginal route having utterly failed. The treatment of hemorrhage, so often present, is one of relative simplicity, and this by means of the firm intrauterine pack, applied by the gentlest method possible, in order to avoid traumatism, which is always the greatest and most potent factor in inviting sloughing of the tumor by causing a lesion of its capsule. It is a very common experience of the writer in cases seen in consultation that these fibroids have been acting harmlessly until after the curette had been used for the removal of the supposed secundines. So often has this been my experience that I would sound a note of warning that the use of the curette in a fibroid uterus recently pregnant or even in a non-pregnant condition, is one fraught with the greatest danger. Its use, in many cases, is absolutely not indicated, but your experience will probably be similar to mine: that just as soon as a puerperal woman has a rise of temperature her physician at once, without much forethought, thinks first, last and all time of the curette. To the average mind fever at this time means sepsis from retained products of conception. The poor uterus stands the brunt of the attack, even though the condition is due to an entirely different cause. The curette has no place in the fibroid uterus, whether puerperal or not. When we are sure, and this can best be certified to by the hand,

*Read at the annual meeting of the Humboldt County Medical Society March 14, 1905.

that the temperature is due to a sapremia sepsis such products in the uterus can and must be removed by the hand; and the curette, under no condition, should ever be employed.

But usually temperature and pulse rise in a fibroid puerperal uterus are due to beginning necrotic changes in the tumor. If we are in doubt we can surely wait for symptoms indicative of these changes. The low temperature, the rapid pulse and the decided local pain in the uterus, with or without the fetid lochia, all make too evident what the lesion is. Intramuscular and submucous fibroids are those that give the best prognosis and the readiest means of extirpation. Examination of the interior of the uterus shows the lacerated capsule and the point of cleavage for a simple enucleation of the tumor. Treatment along simple aseptic lines and attempting to do too little rather than too much, is the best means of overcoming this complication. Sub-peritoneal sloughing fibroids are far more difficult to attack and consequently make the prognosis worse.

To make my position clear as to fibroids complicating pregnancy, I submit the following resume:

1. Prophylaxis. Every fibroid during the childbearing period, with few exceptions, should be attacked by surgical means.

2. During pregnancy. Safe fibroids, i. e., those beyond the dilating zone of the uterus, should be carefully watched. Every complication during pregnancy depending upon the fibroid should warrant our attacking surgically the condition, or, at least provoke us to the indication for emptying the uterus.

3. During labor. Again, safe tumors need watching. The resultant complications must be met energetically, but gently, as they arise, i. e., hemorrhage, tardy labor.

4. Sloughing and necrosis of a puerperal fibroid must not be mistaken for retained secundines. This doubt must be eliminated by exploration with the clean aseptic hand. Retained secundines are always to be removed manually, and under no condition must the curette be employed, because of the great danger of laceration of the capsule, and consequent sepsis.

5. Sloughing and necrotic fibroids are always to be attacked surgically, either by enucleation or by a hysterectomy.

COUNTY SOCIETIES.

Alameda County

The Alameda County Society held its regular monthly meeting on October 16th.

Dr. R. T. Stratton read a paper on "The Treatment of Aneurysm by Direct Gradual Arterial Closure," reporting a case treated by this method.

The paper reviewed the animal experimental work done by Dr. Stratton, reports of which have been previously published, in which he succeeded in dogs in closing large arteries by gradually occluding the vessel by means of a specially devised appliance, the purpose with respect to aneurysm being to promote thrombus formation in the sac by this gradual occlusion of the afferent artery. He has had opportunity to apply this method of treatment to but one case of aneurysm, involving the abdominal aorta. The operation consisted in making an incision through the abdominal wall from the ensiform cartilage to the umbilicus. The tumor was found to be very large and it was very difficult to isolate the aorta above the mass. This was finally accomplished, however, and a tape passed around the vessel, the tape being gradually tightened by means of a windlass on the instrument which Dr. Stratton has devised for this purpose. The tape and instrument having been properly placed, the wound was partly closed and the patient returned to bed. The tape was tightened slightly from time to time, the patient showing no bad effect from the procedure, and on the second day it was considered safe to completely occlude the vessel. This, however, was followed in a few hours by collapse, and the patient died before the vessel could be freed.

Autopsy showed a large aneurysm, from the sac of which the renal arteries and the ciliac axis took their origin. The ligature about the aorta therefore, which was supposed to be below these vessels, had completely cut off the circulation to the important organs supplied by them, and had so caused the patient's death. The location of these vessels could not be determined at the operation, however, and the accident was unavoidable. Examination of the sac showed it to be filled with laminated clot, which would indicate the efficacy of the method, notwithstanding the outcome in this particular case.

Dr. Nusbaumer read a paper on "Quantitative and Qualitative Leukocyte Changes in Some of the More Common Diseases." This paper was a resume of what is known to-day with reference to this subject and dealt especially with the significance of the leukocyte count in the differential diagnosis of various inflammatory and infectious diseases.

T. C. McCLEAVE, Secretary.

Los Angeles County.

The Los Angeles County Medical Association held its first regular meeting after the summer vacation in the Blanchard Building Friday evening October 6, 1905, at 8 P. M.

The minutes of the previous meetings were read and approved.

The first regular paper was entitled "Displacement of the Heart in Phthisis," by Dr. Henry Herbert. Dr. Herbert exhibited a case. Discussion by Drs. Colliver and Herbert.

The second paper was entitled, "The Relation of Our County Medical Association to the Public Health of Los Angeles," by Dr. George H. Kress. Discussion by Drs. Powers, Follensbee, Witherbee, McGarvin, King and Kress.

Dr. Kress introduced resolutions which were unanimously passed and referred to the Council for action.

Tuesday evening, October 24, 1905, at eight o'clock, in the Blanchard Building the Association was addressed by Dr. J. N. McCormack of the A. M. A. Dr. McCormack's address was intensely interesting and brought out a spirited and valuable discussion. It is expected that many of the ideas developed by Dr. McCormack will be taken up by this Association the coming year.

On the following day, Dr. McCormack, accompanied by Dr. Philip Mills Jones, Secretary of the State Society, and Dr. J. M. King, President of this Association, went to Long Beach and organized the Long Beach Branch of the Los Angeles County Association.

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The Los Angeles County Medical Association held a regular meeting in the Blanchard Building Friday evening, November 3, 1905, at 8 o'clock.

The minutes of the previous meeting were read and approved.

The program for the evening consisted of a symposium on "Chronic Interstitial Nephritis," arranged by Dr. J. H. Utley, and read as follows: (1) Etiology, Dr. J. Lee Hagadorn; (2) Pathology and urine analysis, Dr. Rea Smith; (3) Symptomolgy and diagnosis, Dr. J. H. Utley; (4) Nervous manifestations, Dr. H. G. Brainerd; (5) Ingestion of fluids, Dr. J. A. Colliver; (6) Treatment, Dr. Earl Sweet.

Dr. Smith being absent on account of sickness, his paper was read by Dr. Dudley Fulton.

DISCUSSION.

Dr. Wernigk: In the differential diagnosis between the apoplectiform seizure of this disease and true apoplexy or cerebral hemorrhage, the fever curve as mentioned by Dr. Brainerd is very important. Regarding the restriction of fluids, I sometimes allow my patients as much as one and one-half liters of fluid. Most of them do better on less. It is of first importance to preserve compensation and prevent the degeneration of the hypertrophied heart muscle. One remedial measure that has not been mentioned to-night, and that I consider of value in conditions